Appendix A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
Galveston DIVISION

Norberto Atencio

versus

Port America

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CIVIL ACTION NO. _____

EMPLOYMENT DISCRIMINATION COMPLAINT

1. This action is brought under Title VII of the Civil Rights Act of 1964 for employment discrimination. Jurisdiction is conferred by Title 42 United States Code, Section § 2000e-5.

2. The Plaintiff is: Norberto Atencio

Address: 2420 Winnie st
Galveston, Texas 77550

County of Residence: _____

3. The defendant is: Port America

Address: 3828 Wharf Rd
Galveston, TX. 77550

☐ Check here if there are additional defendants. List them on a separate sheet of paper with their complete addresses.

4. The plaintiff has attached to this complaint a copy of the charges filed on NO with the Equal Opportunity Commission.

5. On the date of May 10, 2019 the plaintiff received a Notice of Right to Sue letter issued by the Equal Employment Opportunity Commission; a copy is attached.

6. Because of the plaintiff's:

(a) ☐ race

(b) ☐ color

(c) ☐ sex

(d) ☐ religion

(e) ☑ national orgin,

the defendant has:

(a) ☑ failed to employ the plaintiff

(b) ☑ terminated the plaintiff's employment

(c) ☑ failed to promote the plaintiff

(d) ☑ other: (i)Discrimination under ADA Acts. title III title VII

7. When and how the defendant has discriminated against the plaintiff:

I had accident work. to Port America. 10.15.18. They have Paid me the Worke compensation. And send to the local 20 letter to they no give me more Job to Until Can work 100%.

8. The plaintiff requests that the defendant be ordered:

(a) ☑ to stop discriminating against the plaintiff

(b) ☐ to employ the plaintiff

(c) ☐ to re-employ the plaintiff

(d) ☐ to promote the plaintiff

(e) ☑ to under ADA cts. Intentional discrimination, don't Pay. for Worker Compensation accident: 10/15/2018. Damage and dismissal from Wor' and that;

(f) ☑ the Court grant other relief, including injunctions, damages, costs and attorney's fees.

(Signature of Plaintiff)

Address: 2420 Winnie st. Galveston, TX 77550

Telephone: 832-818-5110.

Appendix B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
_____ DIVISION

Norberto Atencio

versus

Port Americs

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CIVIL ACTION NO. _____

ORIGINAL COMPLAINT

I normally do work for Port America through the I.L.A Local union 20 · Galveston, Texas- The day 10.15.2018 time 16.50 I have accident we was work in the boat at Peir 10. of Galveston Port. then I talk to the Superintendent He made the accident Report And took me to the emergency clinic. I had a checkup included the drug test. At the Third appointment with the doctor, they told me that the company would not pay for the exams and the medical exam. I started the fight with the Work Compensation. I went to se a doctor at the clinic. coastal Health & Wellness through From to ; Our Daily Bread they helped me with medical help. That day 03/22/2019

the Coastal Health & Wellness Clinic: they send me to work but With Restriction: no Prolonged standing And climbing.

the Port America send email to Local 20 Galveston, Tx. to not hire me For that company. at May 18, 2019.

Violating my right to work and the ADA. acts.

Atencio

From: Elliott Crist (Elliott.Crist@portsamerica.com)

To: htorresila20@yahoo.com

Cc: galvestonmgrs@portsamerica.com; William.Barrett@portsamerica.com

Date: Saturday, May 18, 2019, 08:37 AM CDT

Good morning Mr. Torres,

Until this worker obtains a full duty release without restrictions, Ports America will not accept him for any operations.

Thank you,
Elliott

On May 18, 2019, at 8:25 AM, Henry Torres <htorresila20@yahoo.com> wrote:

this is from gulf steve

----- Forwarded Message -----
From: Henry Torres <htorresila20@yahoo.com>
To: Elliott Crist <elliott.crist@portsamerica.com>
Sent: Saturday, May 18, 2019, 08:22:28 AM CDT
Subject:

----- Forwarded Message -----
From: Henry Torres <htorresila20@yahoo.com>
To: Mike Lynch <mike@gulfsteve.com>; Mike Nelson <mike.nelson@metrocruiseservices.com>
Sent: Saturday, May 18, 2019, 07:56:10 AM CDT
Subject:

<5-18-2018 letter atencio.pdf>

409-938-2234 or 281-309-0255

Coastal Health & Wellness

Serving, Healing, Caring

03/22/2019

To Whom It May Concern:

Norberto Atencio is currently under my medical care and may not return to work at this time.

Please excuse Norberto for .1 day

He may return to work on 03/25/2019.

Activity is restricted as follows: no prolonged standing and climbing .

If you require additional information please contact our office.

Sincerely,

Provider:
Varghese, Jija 03/22/2019 2:08 PM

Document generated by: Jija Varghese FNP 03/22/2019

PO BOX 939 - LA MARQUE, TEXAS 77568 - (409) 938-2234

INTERNATIONAL LONGSHOREMEN'S ASSOCIATION
& WEST GULF MARITIME ASSOCIATION

Drug & Alcohol Test Notification Form

ATTENTION COLLECTION SITE: This is your authorization to perform services.
Payment will be rendered by USAMDT of Houston based on (1) valid test results, (2) proper protocol used when testing, and (3) documentation for services requested below.

Notice:

Time of Notice: 16:20 a.m. / (p.m.)
Date: 10.15.18
Location: Ports America-Galveston
Managing Company: Ports America
Full Address: 3828 Wharf Rd Galveston, TX 77550

Must Report to Clinic By:

Date: 10.15.18
Time: 16:50 a.m. / (p.m.)

Workers Information:

Full Name: Norbito ATencio
Phone Number: 409 457 9990
ILA Work #: 153443
ILA Local #: 200

Medical Facility:

Clinic Name: West Isle Urgent Care
Address: 2027 61st street Galveston, TX 77551
Phone: 409-744-9800

Test Type (Both Tests Are Always Required):

[✓] Breath Alcohol Test (BAT)
[✓] Drug Test Lab: Quest Diagnostics Acct # 10291558 Panel # 46633N
NOTE: Direct Observation & Split Specimen Collections Always Required

Reason For Test:

[X] Post Accident [ ] Reasonable Suspicion [ ] Other: _____

Testing Authorization Information:

READ TO THE WORKER: You are notified to appear to the facility above for a drug test as required by the WGMA/ILA Policy on Drugs. Failure to submit to a direct observation drug and alcohol test as specified in this notice or a failure to sign all required forms violates the WGMA/ILA Policy on Drugs and is treated as a refusal to test (same as a positive drug test result). A photo ID is required to take the drug test: Drivers License or TWIC.

Workers Signature	Printed Name	Telephone Number
	Norbito ATencio	409 457-9990

Requesting Manager

Superintendent / Manager Signature	Printed Name	Telephone Number
	Travis Rhodes	813-285-1530

Witness

Witness Signature	Printed Name	Telephone Number
	Joshua J. Bullard	

Send sample to Quest Diagnostics via Federal Express or lab courier same day or no later than the next business day.

Upon completion:
(1) Send BAT & CCF to MRO: MRO@i3Screen.com or fax 303 595 5263
(2) Send CCF, BAT & This Form to USAMDT: Houston@USAMDT.com or fax 832 572 5588

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

5. Doctor's Name and Degree: Irene Lorell Ade MD
(for transmission purposes only)
Date Being Sent: 10·17·18

1. Injured Employee's Name: Norberto Atencio
6. Clinic/Facility Name: WEST ISLE URGENT CARE
9. Employer's Name: Ports America

2. Date of Injury: 10·15·18
3. Social Security Number (last 4): xxx-xx-
7. Clinic/Facility/Doctor Phone & Fax: 409-744-9800 PH 409-744-8844 FAX
10. Employer's Fax # or Email Address (if known):

4. Employee's Description of Injury/Accident: (R) knee Strain
8. Clinic/Facility/Doctor Address (street address): 2027 61ST STREET STE B
City: GALVESTON State: TX Zip: 77551
11. Insurance Carrier: Ports Ins.
12. Carrier's Fax # or Email Address (if known):

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:

☐ (a) will allow the employee to return to work as of _____ (date) **without restrictions**.

☑ (b) will allow the employee to return to work as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the employee from returning to work as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day: 0 2 4 6 8	Other
Standing ☐☑☐☐☐	
Sitting ☐☐☐☐☑	
Kneeling/Squatting ☑☐☐☐☐	
Bending/Stooping ☑☐☐☐☐	
Pushing/Pulling ☐☐☐☐☑	
Twisting ☐☐☐☐☐	
Other: ☐☐☐☐☐	

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ Left Hand/Wrist ☐ Left Leg
☐ Right Hand/Wrist ☐ Right Leg
☐ Left Arm ☐ Back
☐ Right Arm ☐ Left Foot/Ankle
☐ Neck ☐ Right Foot/Ankle

Other:

16. OTHER RESTRICTIONS (if any):
Right Knee

17. MOTION RESTRICTIONS (if any):

Max Hours per day: 0 2 4 6 8	Other
Walking ☐☑☐☐☐	
Climbing stairs/ladders ☑☐☐☐☐	
Grasping/Squeezing ☐☐☐☐☑	
Wrist flexion/extension ☐☐☐☐☑	
Reaching ☐☐☐☐☑	
Overhead Reaching ☐☐☐☐☑	
Keyboarding ☐☐☐☐☐	

Other:

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than _____ lbs. for more than _____ hours per day
☐ May not perform any lifting/carrying

Other:

19. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work: _____
☑ Sit/Stretch breaks of 5 min per 2 hrs.
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No work / _____ hours/day work:
☐ in extreme hot/cold environments
☐ at heights or on scaffolding
☑ Must keep (R) knee ☑ elevated ☐ clean & dry
☐ No skin contact with: _____
☐ Dressing changes necessary at work
☐ No running

20. MEDICATION RESTRICTIONS (if any):

☑ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medication may make drowsy (possible safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:
(R) knee Sprain

22. Expected Follow-up Services Include:

☑ Evaluation by the treating doctor on 10/20/18 (date) at 8 am : 1 pm am/pm
☐ Referral to/Consult with _____ on _____ (date) at _____ : _____ am/pm
☐ Physical medicine _____ X per week for _____ weeks starting on _____ (date) at _____ : _____ am/pm
☐ Special studies (list): _____ on _____ (date) at _____ : _____ am/pm
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit / Discharge Time	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type: ☐ Initial ☑ Follow-up	Role of Doctor: ☐ Designated doctor ☑ Treating doctor ☐ Referral doctor ☐ Consulting doctor	☐ Carrier-selected RME ☐ DWC-selected RME ☐ Other doctor

DIVISION OF WORKERS' COMPENSATION

Employee - You are required to report your injury to your employer within 30 days if your employer has workers compensation insurance. You have the right to free assistance from the Texas Department of Insurance Division of Workers Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800) 252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

5. Doctor's Name and Degree: Irene Ornell Adu MD

(for transmission purposes):

Date Being Sent: 10-17-18

1. Injured Employee's Name: Norberto Atencio

6. Clinic/Facility Name: WEST ISLE URGENT CARE

9. Employer's Name: Ports America

2. Date of Injury: 10-15-18

3. Social Security Number (last 4): xxx-xx-

7. Clinic/Facility/Doctor Phone & Fax: 409-744-9800 PH 409-744-8844 FAX

10. Employer's Fax # or Email Address (if known):

4. Employee's Description of Injury/Accident: (R) knee strain

8. Clinic/Facilty/Doctor Address (street address): 2027 61ST STREET STE B

City: GALVESTON State: TX Zip: 77551

11. Insurance Carrier: Ports Ins.

12. Carrier's Fax # or Email Address (if known):

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury

- ☐ (a) will allow the employee to return to work as of _____ (date) without restrictions
- ☑ (b) will allow the employee to return to work as of _____ (date) with the restrictions identified in PART III through _____ (date).
- ☐ (c) has prevented and still prevents the employee from returning to work as of _____ (date) and is expected to continue

The following describes how this injury prevents the employee from returning to work:

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14. POSTURE RESTRICTIONS (If any):

Max Hours per day: 0 2 4 6 8	Other
Standing ☐☑☐☐☐	
Sitting ☐☐☐☐☑	
Kneeling/Squatting ☑☐☐☐☐	
Bending/Stooping ☑☐☐☐☐	
Pushing/Pulling ☐☐☐☐☑	
Twisting ☐☐☐☐☐	
Other: ☐☐☐☐☐	

15. RESTRICTIONS SPECIFIC TO (If applicable):

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- ☐ Neck
- ☐ Left Leg
- ☐ Right Leg
- ☐ Back
- ☐ Left Foot/Ankle
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Other:

16. OTHER RESTRICTIONS (If any):

Right Knee

17. MOTION RESTRICTIONS (If any):

Max Hours per day: 0 2 4 6 8	Other
Walking ☐☑☐☐☐	
Climbing stairs/ladders ☑☐☐☐☐	
Grasping/Squeezing ☐☐☐☐☐	
Wrist flexion/extension ☐☐☐☐☑	
Reaching ☐☐☐☐☑	
Overhead Reaching ☐☐☐☐☑	
Keyboarding ☐☐☐☐	

Other:

18. LIFT/CARRY RESTRICTIONS (If any):

- ☐ May not lift/carry objects more than _____ lbs. for more than _____ hours per day
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19. MISC. RESTRICTIONS (If any):

- ☐ Max hours per day of work: _____
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- ☐ Must wear splint/cast at work
- ☐ Must use crutches at all times
- ☐ No driving/operating heavy equipment
- ☐ Can only drive automatic transmission
- ☐ No work / _____ hours/day work:
  - ☐ in extreme hot/cold environments
  - ☐ at heights or on scaffolding
- ☑ Must keep (R) knee elevated ☐ clean &
- ☐ No skin contact with: _____
- ☐ Dressing changes necessary at work:
- ☐ No running

20. MEDICATION RESTRICTIONS (If any):

- ☑ Must take prescription medication(s)
- ☐ Advised to take over-the-counter meds
- ☐ Medication may make drowsy (possible safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

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21. Work Injury Diagnosis Information:

(R) knee sprain

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- ☐ Referral to/Consult with _____ on _____ (date) at _____ : _____ am/pm
- ☐ Physical medicine _____ X per week for _____ weeks starting on _____ (date) at _____ : _____ am/pm
- ☐ Special studies (list): _____ on _____ (date) at _____ : _____ am/pm
- ☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type: ☐ Initial ☑ Follow-up	Role of Doctor: ☑ Designated doctor ☑ Treating doctor ☐ Referral doctor ☐ Consulting doctor	☐ Carrier-selected RME ☐ DWC-selected RME ☐ Other doctor
Discharge Time					